Priority Health	BILLING POLICY No. 092

REIMBURSEMENT REQUIREMENTS FOR OUTPATIENT MEDICAL DRUGS

Date of origin: June 19, 2025	Review dates: 10/2025, 2/2026, 6/2026, 9/2026

POLICY OVERVIEW

Priority Health aims to serve members in accordance with our medical policy coverage criteria and in care settings that are both safe and cost-effective. This policy outlines reimbursement requirements for select infusions, injectables, and specialty drugs to be administered at the most cost-effective place of service. These requirements ensure consistent, site-neutral management of high-cost medical drugs and reduces markups on facility-sourced drugs. The intent is to make care more affordable for members.

DEFINITION

- Fully funded (fully insured) commercial products are employer-offered group health plans that transfer claims risk from the employer to the insurance carrier. The employer pays a predetermined premium, while the insurer is responsible for administering benefits and paying covered medical claims.
- Self-funded commercial products are employer-sponsored benefit arrangements in which the employer assumes responsibility for funding covered medical claims using its own assets. While administrative functions may be delegated to a third-party administrator, the employer retains the underlying financial risk for healthcare costs.

For Fully and Self-Funded Commercial Products

Priority Health requires that members receive selected infusions or injections to have the infusion or injection in the home or office setting, or an alternative Priority Health-approved site of care.

The Reimbursement Requirements for Outpatient Medical Drugs policy applies when:

1. Requested therapy is included on the Medical Drug List with the Site of Service (SOS) restriction denoted.
    - Examples include, but are not limited to:
        - Soliris (J1299; Injection, eculizumab, 2 mg)
2. A medical injectable drug is administered in an outpatient hospital setting, not on Priority Health's Standard Fee Schedule.

When the above are met, Priority Health will require the member to receive their therapy at an alternative Priority Health-approved site of care.

Exceptions to this policy may occur when:
The members may continue receiving their therapy at the non-covered site of service when the drug is obtained at an in-network specialty pharmacy. The drug must be dispensed by a specialty of pharmacy, and providers may directly submit a claim for the administration of the medication only.

If the requested medication is **not** available at an in-network specialty pharmacy, the provider can request an exception by submitting a prior authorization to the Pharmacy Department at Priority Health. This can be done by faxing a completed medical drug prior to authorization form to 877.974.4411. Additional support can be provided by calling 800.942.0954. The request must provide a member-specific medical necessity rationale for exception. An exception may be considered for the following:

a) Starting dose(s) only when multiple administrations are required and provided that the medication is not subject to limited distribution. All subsequent doses will be subject to this policy.

b) Complexity of the infusion required by an individual is such that it can only be performed safely and effectively by or under the supervision of a specialty skilled nursing personnel.
c) History of infusion reactions leading to serious adverse events despite management with pre-medication and infusion rate control.
d) History of severe adverse events following an infusion (i.e., anaphylaxis, seizure, thromboembolism, myocardial infarction, and renal failure).
e) Medically unstable situations (e.g., unstable renal function, unstable vascular access).
f) Distance (in miles) from the nearest approved site of service.
g) Members receiving immune checkpoint inhibitors in combination with provider-administered chemotherapy on the same day.

Please note: Exceptions for gene and cell therapy are excluded from the above exception criteria and will be assessed on a case-by-case basis.

For Medicaid and Healthy Michigan Plan
Priority Health requires that members receiving select provider-administered drugs must have the drug administered at a Priority Health-approved site of service.

Exceptions to this policy may be granted if the member has a documented history of infusion reactions or severe adverse events, for medically unstable situations, or the distance to an approved site of care is unreasonable.

For both Fully or Self-Funded Commercial Products and Medicaid/Healthy Michigan

Medications with these requirements can be found on Priority Health's Drug Information page. Priority Health's Medical Drug List can also be found in our Provider Manual and/or the Medical Drug List - Search tool.

Priority Health may add or remove site of care requirements to drugs as new therapies become available, as pharmacy distribution changes, or as cost-effectiveness strategies evolve. Changes to the list will be reflected on the Medical Drug List. Providers are responsible for verifying whether the medication is on the current list at the time of service. Site of Service requirements also applies to any non-formulary medications approved through the exception process.

Additional prior authorization may be required to establish medical necessity of treatment. Specific coverage criteria can be found on Priority Health's Medical Drug List. If a requested medication has prior authorization requirements, the provider/member must obtain a favorable coverage decision in addition to the above requirements for place of service.

FOR MEDICARE

For indications that don't meet the criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual

POLICY SPECIFIC INFORMATION

Contracted pharmacy details
The following list shows in-network specialty pharmacy providers as of 10/27/2025.

1. **Accredo Specialty Pharmacy**
    1. Prescriptions may be sent directly to Accredo Specialty.
    2. Phone: 877.222.7336
    3. Fax: 888.979.8904

2. **Optimed Specialty Pharmacy**
    1. Prescriptions may be sent directly to Optimed Specialty Pharmacy.
    2. Phone: 877.385.0535
    3. Fax: 877.326.2856

Additional contracted specialty pharmacies may be utilized when coordinated in advance with Priority

Health. This list is not all-inclusive and is subject to change based on contractual agreements.

Drugs subject to

Review Priority Health's Medical Drug List to verify the medications subject to the Reimbursement Requirements for Outpatient Medical Drugs policy. Providers should refer to this list to determine if a requested drug will require a specialty pharmacy. Priority Health's Medical Drug List can also be found in our Provider Manual and/or the Medical Drug List - Search tool

Drug coverage may still require prior authorization under this policy. Drug coverage criteria can be found in our Provider Manual. If a requested drug has coverage requirements, a member or provider must submit a prior authorization request and receive a favorable coverage decision before a specialty pharmacy can bill and dispense the requested drug. The request must mention "Specialty Pharmacy" in the "Billing" section of the prior authorization form.

Updates to include drugs

Priority Health's Medical Drug List is subject to periodic review and updates following decisions made by Priority Health's Pharmacy and Therapeutics Committee. Priority Health may add or remove drugs as new therapies become available, as pharmacy distribution changes or as cost-effectiveness strategies evolve. Changes to the list will be reflected in the Medical Drug List with effective dates. Providers are responsible for verifying whether medication is on the current list at the time of service.

Requests for exception to the Reimbursement Requirements for Outpatient Medical Drugs policy should be submitted as prior authorization requests to the Pharmacy Department at Priority Health, including a rationale as to why the request is being made. This can be done by faxing a completed Medical drug prior authorization form to 877.974.4411. Additional support can be provided by calling 800.942.0954.

For Fully and Self-Funded Commercial Products, when drug acquisition from a contracted specialty pharmacy is not an option, Priority Health requires that patients receive selected infusions or injections to have the infusion or injection in the home or office setting, or an alternative Priority Health-approved site of service. An exception may be considered based on medical necessity.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and conditions. Authorization may be required. Get more information in our Provider Manual.

This policy applies to the listed drugs dispensed in an outpatient facility place of service only.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to the procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.
An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT,

HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non- participating providers and facilities.

If guidelines are detailed in government program regulations, defined in policies, and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual

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CHANGE / REVIEW HISTORY

Date	Revisions made
Oct. 2025	The following updates will be **effective Jan. 1, 2026**: • Changed policy name to Reimbursement Requirements for Outpatient Medical Drugs • Expanded policy to apply to in-network (as it previously applied to only out-of-network providers) • Expanded definition to clarify when this policy applies and when it may not
Feb. 2026	Clarifying language from the pharmacy
June 2026	J9271 was removed from the example portion, as this code has been removed from the edit
Sept. 2026	Policy overview and added definitions